

Policing and Homelessness: Using Partnerships to Address a Cross System Issue

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April 2016

Word count: 6532

The Version of Record of this manuscript has been published and is available in *Policing: A Journal of Policy and Practice* May 3, 2016
<http://policing.oxfordjournals.org/content/early/2016/05/03/police.paw010>

Abstract

Increasingly, law enforcement agencies have been forced to become more creative in their problem solving efforts, that is, do more with less. Arresting their way out of a problem is not always the best response on many levels given the cost to taxpayers as well as the possible strain put on community relationships. Given the other realization that some problems are not solely police problems, solving problems using multi-agency partnerships has gained traction and there is evidence to support these partnerships as viable options. This manuscript presents a pilot study of a problem-solving effort in Indianapolis, Indiana grounded in multi-agency partnerships. Led by the Indianapolis Metropolitan Police Department, the goal was to reduce the burden of mentally ill and/or addicted homeless individuals on the criminal justice and emergency medical services systems. It serves to inform both academics and practitioners about an innovative strategy occurring in Indianapolis which may help relieve some of the economic burden on the criminal justice system and ultimately decrease the homeless population.

Keywords:

Problem solving, partnerships, homeless, mentally ill, SARA Model

Introduction

While not a crime in itself, homelessness is increasingly becoming a public safety issue as business owners, tourists, commuters, and neighborhood residents look to law enforcement to manage the homeless population. And, as Buffington-Vollum (2012) suggests, the relationship of homelessness to mental illness simply cannot be ignored (see, for example, Drake et al. 1991; Fischer and Breakey 1991; Levine and Huebner 1991). However, responding to calls for service involving homeless individuals is not commonly included in police academy training. In some instances, the solution has been to criminalize homelessness, and many jurisdictions are enacting local ordinances that restrict the movements of the homeless, which results in more frequent arrest and incarceration (see, for example, Fang 2009; Greenberg and Rosenheck 2008; Kushel et al. 2005; McNiel et al. 2005). Given that some criminal justice issues are not just police matters, multi-agency partnerships have gained traction as a means of addressing these issues (Council of State Governments 2002; Lamb et al. 2002; Normore et al. 2015). Normore et al (2015) suggest that these partnerships are critical options and recommends that police organizations partner with mental health agencies in an effort to create a better response to homeless individuals with mental health issues.

How might police partnerships address the issue of better serving homeless and mentally ill populations? Using retrospective data from Indianapolis, Indiana, this case study (Creswell 2012) explores how the Indianapolis Metropolitan Police Department (IMPD) Homelessness and Panhandling Unit (HPU) created a climate of partnerships to address mental illness, addiction, crime and victimization, emergency and transitional housing, and other social services for the homeless population in the city. The police sought, when possible, non-arrest alternatives to working with homeless individuals suffering from mental illness. This study's aim is to identify for both academics and practitioners a non-arrest based innovative strategy in practice in

Indianapolis that serves as a model for both relieving some of the economic burden on the criminal justice system caused by policing homelessness and, ultimately, decreasing the chronic homeless population. This project is atypical in that it originated as a criminal justice program from within the police department, and not as part of a grant-funded intervention. As such, the project lacks some of the markers of a research project such as detailed data collection as it relates to contact with the homeless and mentally ill as well as rigorous process and outcome evaluations. This oversight is not uncommon in criminal justice program implementation. And, despite this omission, what information and data are available present feasible options to jurisdictions facing similar issues with a homeless, mentally ill population (Nagin and Weisburd 2013).

Literature Review

Policing, Mental Illness, and Homelessness

The 1960s and 1970s, the deinstitutionalization movement in the United States intended for the mentally ill to receive better services and care outside of mental institutions. Deinstitutionalization proponents anticipated that family and community support would be a vital component of the deinstitutionalization process, and would improve the quality of life for former inpatients. Unfortunately, for most, these support systems never materialized. And given this reality, many of the former inpatients became homeless (Lamb and Weinberger 1998; Mechanic and Rochefort 1990), sought self-medication with drugs and/or alcohol (Caton et al. 2005; Kertesz et al. 2005; Padgett et al. 2006), and often times, became involved in the criminal justice system (Buffington-Vollum 2012) and/or ended up incarcerated (Bachrach 1996; Lamb and Weinberger 2005; Steadman et al. 2009). In fact, deinstitutionalization, alongside the push for increased incarceration in the 1990s, has rendered the criminal justice system as the de facto mental health system for many individuals (Johnson 2011). The proportion of individuals

incarcerated with a serious mental illness is higher than that of the general population (Lamb and Weinberger 1998; Steadman and Cocozza 1993). Indeed, the number of psychiatric inpatients has decreased 95% from 1955 to 2000 (Lamb and Weinberger 2005). Given that there is only so much money to go around, allocating funds for imprisonment creates gaps in funding in other areas like mental health services, among others (Johnson 2011).

By the nature of their occupation, police officers routinely come face to face with individuals who have mental health issues (see for example, Bittner 1967; Teplin and Pruett 1992). In 1967, Bittner described the discretion police officers had when responding to civil matters involving individuals with mental illness; in the intervening years, police officers' dispositional options have decreased due to further restrictions placed on criteria and procedures for commitment (Teplin 1983, 1984). Additionally, several United States Supreme Court case decisions in the 1970s and early 1980s confirmed the right of mentally ill individuals to live without treatment (Teplin 1984). Protecting both the public and those who cannot protect themselves (i.e., *parens patriae*¹) such as the mentally ill, has magnified the role of the police officer as a gatekeeper to the criminal justice system as well as the mental health system (Lamb et al. 2002).

Homeless individuals who are also mentally ill create unique challenges for each part of the criminal justice system. While concrete figures are hard to come by due to the nature of the population, generally accepted estimates are that one-third of the homeless population has some sort of mental illness. Others estimate 25 percent have a *serious* mental illness (SMI) (Caton et al., 2005; Kertesz et al., 2005; Padgett, Gulcur, & Tsemberis, 2006). The arrest of a mentally ill

¹ The state as the parent. *Parens patriae* is a doctrine that grants the inherent power and authority to the state to protect person who are legally unable to act on their own behalf such as children, mentally ill individuals, and others who are legally incompetent to manage their own affairs because they are incapacitated or disabled.

homeless individual sets off a chain of events that may take years and considerable resources to conclude. The current criminal justice system is not user-friendly for someone who, in addition to being mentally ill and homeless, most likely does not have a support system in place to bring prescription medications to the jail, a job to pay court costs and fees resulting from the arrest and jail stay, a clock, alarm, or calendar to alert them to upcoming appointments or court dates, and reliable transportation to get to those appointments or required court appearances, just to name a few challenges faced by homeless individuals who are mentally ill. The cycle therefore becomes arrest, release, failure to appear in court, warrant issued for arrest, and then repeat. Getting needed services as well as escaping the cycle is difficult. In the current public safety atmosphere of ‘do more with less,’ police must recognize that forming multi-agency partnerships may both improve response to mentally ill homeless individuals and save time, resources, and lives.

In an effort to combat the unintended consequence of the ‘criminalization of the mentally ill’ (Abramson 1972) since deinstitutionalization, many police departments have engaged in pre-arrest diversion programs (see, for example, Cordner 2006; Finn and Sullivan 1989; Perez et al. 2003). One of the most well-known programs across the United States is the Crisis Intervention Team (CIT) used by law enforcement officers. CIT training is delivered by the National Alliance on Mental Illness (NAMI). The program builds ‘on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness’ and seeks to improve law enforcement and community responses to individuals experiencing mental health crises (National Alliance on Mental Illness 2015). CIT trains officers on how to recognize different mental illness conditions and how to best approach mentally ill individuals during the course of a call for service, that is, how to work with the individual and his or her family for support.

Research surrounding the police and mentally ill tends to focus on these pre-arrest crisis situations and possible alternatives to arrest. For example, research conducted in three jurisdictions (Birmingham, AL, Knoxville and Memphis, TN) examined three different police responses to calls for service involving mentally ill individuals in crises (i.e., emotionally disturbed). The police arrested the individual only seven percent of the time. Other options included resolving the incident at the scene (most frequent response in Birmingham), or by referral to a mental health professional (most common in Knoxville) (Steadman et al. 2000). And, while Teller et al. (2006) saw no change in the arrest rates of mentally ill persons after CIT program implementation in Akron, Ohio, they did find higher rates of mental health transports and referrals, including voluntary, to emergency treatment facilities. This shift in tactics demonstrates a non-criminal justice response to increased calls for service. In the face of growing numbers of calls for service that involved mentally ill citizens, maintaining the number of arrests actually reflects a percentage reduction in arrests overall.

And, while policing organizations differ across the world, there is consensus that the police response to the mentally ill must be enhanced. Canada and Australia have adopted similar models to the American CIT model which include increased mental health training for the police as well as increased cross-system collaborations to ensure a non-arrest based response to mentally ill individuals when appropriate (Wood and Beierschmitt 2014). Similarly, in the United States and abroad, there is acknowledgment about the lack of, as well as calls for, earlier or ‘upstream’ pre-arrest responses to the mentally ill (Cordner 2006; Sainsbury Center for Mental Health 2009; Victoria Police 2007; Wood and Beierschmitt 2014).

Criminal justice is no longer the linear process as is it commonly portrayed of case processing starting with the police, then the courts, and then corrections. The realization that the

police cannot always solve problems alone has emerged over a span of many years. The need for, and apparent success, of multi-agency responses to crime problems cannot be ignored (Klofas et al. 2010). This along with the evidenced based success of focused, data-driven diagnosis and response is creating opportunities for police departments *and their partners* to embark in creative problem solving.

Models of Police Problem-Solving and Partnerships

In the last three decades, the police have formed increasing numbers of partnerships with various agencies in an effort to address assorted criminal justice issues. This is true in American policing as well as internationally. These problem solving collaborations acknowledge the power of a multi-agency response and expanded skill set as well as the advantages of pooling resources. So much so that in the United Kingdom, the Crime and Disorder Act of 1998 legislated that the police and local authorities use partnerships as part of a police reform agenda (Fleming 2006; Newburn 2008). However, the United Kingdom is not the norm as most police partnerships are not legislatively supported.

In the United States, there are several well-known examples of successful multi-agency initiatives from the late 1990s and 2000s aimed at combating various forms of violent crime. These partnerships, while not grounded in any legislation like the United Kingdom's Crime and Disorder Act, were funded through federal grant funds. Boston's Operation Ceasefire (Braga et al. 2001; Piehl et al. 2000) observed a 60% reduction in youth homicides when they employed a working group comprised of law enforcement and social service agencies to as part of the problem solving efforts. The Strategic Approaches to Community Safety Initiative (SACSI) was a federally funded program in ten sites where the U.S. Attorney convened multi-agency working groups who developed specific interventions tailored to a local crime problem. A national

evaluation of the project comparing crimes trends in the ten SACSI sites to comparable cities found associated declines in targeted crimes such as homicides and violent crime in the SACSI sites (Roehl et al. 2008).

The SACSI project laid the groundwork for Project Safe Neighborhoods (PSN), a national gun violence reduction program, in which one of the five core components is increased partnerships between federal, state, and local agencies. Here, a national evaluation comparing PSN targets cities to non-PSN target cities found that in sites where PSN was implemented to include multi-agency partnerships (as the program intended), PSN target cities experienced a 4.1 percent decline in violent crime compared to a 0.9 percent decline in non-target cities (McGarrell et al. 2010). Problem solving initiatives grounded in multi-agency partnerships continue to be favorable evidenced based practices among law enforcement agencies.

The problem solving partnership initiatives reviewed thus far were, for the most part, aimed at reducing violent crime. However, mentally ill individuals do not tend to make their way into the criminal justice system for committing acts of violent crime - four of the five most common offenses for which mentally ill individuals are charged are non-violent (Torrey et al. 1998). A recent Campbell systematic review examined the effectiveness of problem-oriented policing using the SARA (Scanning, Analysis, Response, and Assessment) Model (Eck and Spelman 1987) in reducing crime and disorder more broadly. The authors reviewed both less rigorous pre/post studies and ten more rigorous studies that met their methodological inclusion criteria. Results indicated a modest yet significant effect on crime and disorder for the ten studies and even more positive results for the less rigorous studies (Weisburd et al. 2010).

Homelessness in Indianapolis, Indiana

‘Point in time’ homeless counts estimate that there are between 200 and 250 homeless individuals - specifically those individuals living on the streets or under bridges, not in emergency shelters² - in Indianapolis on any given day and many of these individuals self-report mental illness or addiction issues (Majors et al. 2014). Unlike CIT officer interactions discussed previously which most often occur during calls for service, the police are not always responding to or interacting with homeless individuals who are in a mental health *crisis* at that moment. That is, these police interactions do not always involve calls for service from the public or concerned family members. Indeed, the typical law enforcement response to calls for service regarding homeless individuals in Indianapolis was arrest, seizure of any property, and posting of ‘no trespassing’ signs.

In 2008, the American Civil Liberties Union of Indiana filed a class-action lawsuit on behalf of individuals experiencing homelessness in Indianapolis claiming the City of Indianapolis encouraged policy and practice that violated the plaintiffs’ First, Fourth, and Fourteenth Amendments rights, as guaranteed by the United States Constitution.³ The lawsuit alleged that IMPD routinely forbade lawful solicitation by homeless individuals (e.g., ‘cup shaking’ or sign holding) (First Amendment violation), seized (i.e. detained) homeless individuals without cause or suspicion until they could produce identification (Fourth Amendment violation), and seized and destroyed property of homeless individuals without

² While there are many definitions of homelessness, law enforcement primarily encounter homeless individuals who meet the U.S. Department of Housing and Urban Development (HUD) criteria of having a primary nighttime residence or place he or she resides that is not meant for human habitation, such as a car, park, sidewalk, abandoned building, bus station, airport etc., that is, he or she is an ‘unsheltered’ homeless individual. A ‘sheltered’ homeless individual is someone who resides in an emergency shelter or transitional housing for persons who originally came from the streets or emergency shelters [found in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (P.L. 111-22, Section 1003)]. And within this definition there are the short-term homeless, the long-term homeless, and the chronically homeless.

³ United States District Court, Southern District of Indiana, Indianapolis Division Case No. 1:08-cv-780, filed July 2, 2008.

cause, notice, or an opportunity to be heard (Fourth and Fourteenth Amendments violations). At the time, IMPD did not have a specialized unit or specific officers who were trained to respond to calls for service regarding homeless individuals and, undeniably, these actions by officers were not atypical. In response to the lawsuit, IMPD created a written policy guiding police officer interactions with homeless individuals.⁴ The formalization of a policy for interactions with the homeless by IMPD satisfied the plaintiffs, and the ACLU dropped the lawsuit. Also as a result, IMPD assigned the sergeant in charge of Strategic Projects the task of addressing the homelessness issue.

IMPD Homelessness and Panhandling Unit

The sergeant tasked with addressing the homelessness issue recognized quite quickly that he needed more manpower given the number of homeless individuals in Indianapolis.. After a period of time of operating with just two officers, the Homelessness and Panhandling Unit (HPU) was formally created in 2011 to address the immediate need in the community: to connect homeless individuals to shelter and services while keeping them out of the criminal justice system if at all possible. Within two years, the unit was fully staffed with one sergeant and four patrol officers all of whom are CIT trained.

On any given day, HPU officers might respond to a complaint about a homeless individual or camp, accompany medical or social service outreach workers to camps, search for missing individuals, or simply check on a particularly vulnerable individual. Complaints handled by the unit may be formal, via the Mayor's Action Center hotline, the HPU-specific email, or voicemail; more informal complaints may arrive through a personal phone call from another police officer or agency partner. The HPU also accepts detective cases that have a homelessness

⁴ IMPD General Order 1.21 *Interactions with Homeless Persons* effective November 19, 2009, revised November 30, 2012.

component, that is, the victim, suspect, or a witness is homeless. And, the HPU works directly with the Department of Public Works when there is a planned ‘clean up’ of any area that might be considered a homeless camp.

Using SARA to Address the Homeless

IMPD has taken an innovative approach to addressing and the serving the homeless population in Marion County and addressing attendant concerns. As noted earlier, IMPD created the HPU because of increased complaints from citizens about homeless camps both on public and private property, homeless people loitering in public places, among other common nuisance-like (but mostly non-criminal) issues. District officers were repeatedly responding to radio runs and interacting with homeless individuals who they believed suffered from mental illness, addiction, or some combination of both.

Knowing that a purely legal response to homelessness would not be effective (Eck 2003; Sherman et al. 2002), the sergeant approached the issue by applying a commonly used problem-oriented policing methodology known as the SARA (Scanning, Analysis, Response, and Assessment) Model (Eck and Spelman 1987).⁵ Problem-oriented policing (POP) (Goldstein 1979) would allow IMPD to address the non-legal issues associated with homelessness; the SARA model would guide a problem-based proactive response rather than an incident-based reactive response. This kind of response would be in contrast to the manner in which IMPD had been responding which was not legal in many instances, and, frankly, not working. Using four steps, the SARA model helps guide police to identify problems, determine their underlying causes, and implement and assess evidence-based responses (Eck 2003). While assessment is the

⁵ A long discussion on SARA is omitted intentionally as it is not the focus of the article. It is discussed in an attempt to accurately reflect the sequence of events.

fourth step, given that police officers are using this technique, it does not always entail formal, rigorous outcome evaluation.

The scanning or problem-identification step revealed several points: 1) district officers were repeatedly responding to calls for service that involved interactions with homeless individuals; 2) responding officers believed that the majority of the homeless individuals suffered from mental illness and/or addiction; 3) officers were frustrated in that most interactions with homeless individuals did not lead to a satisfactory outcome; and 4) responding to homeless individual related calls was a drain on limited police resources. Despite the fact that an arrest would only address that specific incident and not the problem, it was the most likely outcome because officers did not perceive an alternative.

After identifying the problem, the next step in the SARA process is analysis. The goal of this step is to create a better understanding of the problem: why it occurs, how it is currently addressed. The sergeant conducted internal research including talking to street officers and requesting data from various sources, more traditional external research using conventional sources, as well as talking with peers at other law enforcement agencies. The analysis revealed three things about the City of Indianapolis: 1) the City had organizations that conducted homeless outreach, but outreach workers had limited exposure to mental health training; 2) the City had sporadic mental health outreach to homeless individuals who were not residing in shelters; 3) there was no comprehensive or coordinated mechanism for dealing with the homeless suffering from mental illness and/or addiction. Now that they had a better understanding of the problem, the HPU took it upon themselves to work towards developing a better response.

At the time, IMPD did not have much data about the homeless population which would help direct their response to the identified problem. A common but inaccurate perception was

that homeless individuals suffering from mental illness were dangerous; this assertion was mostly conjecture, however but supported by the common arrest-based response by IMPD officers. With input from various IMPD units, the HPU identified twenty homeless individuals who suffered from mental illness and/or addiction and who had frequent law enforcement contact. Such individuals are also known as ‘frequent fliers’ or ‘chronic consumers’ (Akins et al. 2014; Ford 2005; Houston Police Department 2010). The intent of this exercise was to draft a composite picture of the homeless population generally, and specifically of those who were known to have a disproportionately high number of contacts (i.e., arrests) with law enforcement. There was no real attempt by the HPU to be systematic for the purposes of research and there was no attempt to create a control group list for comparison. It is not uncommon for law enforcement to create chronic offender lists (i.e., worst of the worst lists, frequent flyer lists, etc.) in this fashion in an attempt to direct limited resources for the most benefit (see, for example, Bynum et al. 2006; Houston Police Department 2010). Quick criminal history checks⁶ on the 20 identified individuals confirmed they were indeed the focus of considerable criminal justice resources, however, just not in the way officers and the public thought. From the mid-1980s to 2011, the 20 identified individuals accounted for 1070 combined arrests, the majority of which were alcohol use related. One individual accounted for 206 of the arrests (19%). See Appendix A for more details on the 1070 arrests.

Creating the Community Outreach Taskforce (COT Force)

The third step in the SARA model is response. Based on information and understanding of the problem developed during the first two steps, a response to the problem is developed and implemented. This step is where actions and effectiveness are tested; it is often the lengthiest

⁶ Criminal history data included information on arrests occurring in Marion County (Indianapolis) only.

step in the SARA problem solving model. In this case, the response would be grounded in partnerships between IMPD and other stakeholders in Indianapolis responding to the issue of homelessness.

The analysis step created an opportunity for the sergeant to meet the mental health court judge to discuss the specific issues concerning the police department and its interactions with the homeless population. This initial meeting led to a larger meeting in August 2009, facilitated by the judge, of all stakeholders in Marion County related to the homeless and the mentally ill. Over 60 people attended this meeting including stakeholders from across the criminal justice system and public safety as well as from homeless outreach organizations, service providers, and medical and mental health providers. This was the *first time* any such meeting had been held as well as the first time many of the attendees had been in the same room together despite their common target populations. The message was clear and supported the problem identification and analysis steps undertaken by the HPU: The City lacked a coordinated effort to address homeless individuals suffering from mental health and/or substance abuse issues. And, there was also the acknowledgement that the public safety response was ineffective. The police, prosecutor, and courts were seeing the same individuals (i.e., chronic consumers) over and over again, usually for the same alcohol-related offenses.

In order to implement changes especially in police procedures, the sergeant created a working group consisting of stakeholders from the original large meeting. The working group was first known as the Homeless Mental Health Case Conferencing group, and is now known as Community Outreach Taskforce (COT Force). The group set a goal of addressing homeless individuals with mental illness and/or addictions issues that were chronic consumers of law

enforcement resources (the group did not include frequent EMS or emergency department use at first).

The COT Force operates as a task force and does not have any full-time employees. To be nominated for COT Force intervention, an individual must be currently homeless or must be known as chronically homeless. The individual must also have a mental health diagnosis and/or a substance abuse issue, and finally, have frequent law enforcement or hospital emergency department contact. These individuals are the homeless ‘frequent fliers.’

Any COT force member can nominate a homeless individual with mental health and/or addiction issues he or she feels meets the COT Force criteria mentioned above. Once a COT Force member makes a nomination, IMPD team members research the individual in police data systems looking for any contact he or she has had with law enforcement as either a perpetrator or a victim. The EMS team member also conducts research looking for EMS and emergency department contacts involving the nominee. After this groundwork is complete, IMPD and EMS members report back to the entire COT Force and the group decides whether or not to continue on with the nominee as a COT Force client.

[INSERT FIGURE 1 ABOUT HERE]

If the group agrees to add the nominee as a COT Force client, the next step is for the referring group member (or the member who has the best relationship with the nominee) to approach the nominee, explain the opportunity to become a COT Force client, and obtain a signed release of information (ROI) from him or her. The ROI was developed to facilitate the open discussion of COT Force participants. The ROI includes all the COT Force members, and by signing it, the participant waives some privacy rights that would otherwise prevent discussion and coordination of recommended services (e.g., Health Insurance Portability and Accountability

Act, [HIPPA]). The signed ROI allows COT Force members to discuss physical health, mental health, and criminal records with each other. Nominees can decline participation and leave the program at any time.

With a signed ROI on file, COT Force will conduct the modified incident review (Klofas et al. 2006), examining mental health diagnoses and current treatment, arrests, case reports, pending court cases, probation status, and outreach connections. The group then develops a treatment plan for the client. This plan might include drug and/or alcohol detoxification, vocational rehabilitation, job training, applying for disability services, obtaining an identification card, obtaining and taking medications consistently, or life skills training. The next step is to encourage the client to engage in the treatment plan using a one or more of a variety of options. Sometimes, this treatment occurs voluntarily; COT Force describes it as being ready when the individual is ready. Sometimes, it occurs as the result of immediate detention, street plea bargains, court sentencing, or outreach relationships.

The point of contact (POC) for the client is a COT Force member who also serves as the ad hoc case manager for the client. The POC works with the client to help him or her navigate appointments, transportation, and any other potential barriers that may arise as the client works his or her way through the treatment plan. From this point on, the client mainly has interaction with the POC. However, through the partnerships established by COT Force, the entire group adds another layer of supervision, accountability, and support for the client beyond just the ad hoc case manager. And, the monthly meetings serve as a forum for updates on clients from all COT Force members as well as a time to make plan adjustments if needed.

COT Force has established cross-system communication channels that help them monitor COT Force Clients, although there is no formal 'flag' on a COT Force Client that would appear

if, for example, a non-HPU police officer arrested a client. The notification systems in place are informal but cover arrests, emergency department visits, and EMS transports. Therefore, if a client is arrested, the jail will notify the HPU or perhaps an outreach agency who will work to get the client what he or she needs while in jail and then also try and get the client to commit to services such as detox or an appointment with a mental health professional upon release. COT Force clients remain clients as long as they are willing or until they complete their individualized goals. Arrest, relapse, etc. are not causes for expulsion from the program. An unintended diffusion of benefits from this cross-system communication is that the notification mentioned happens for similar homeless individuals who are not COT Force clients.

The fourth step in the SARA process is assessment. This step involves at least a process evaluation and can include an outcome evaluation to determine if the project goals and objectives were met. In this case, COT Force members conducted a self-assessment.

COT Force began accepting clients in the fall of 2009. It is worth noting again that client participation is voluntary. In the first year, the group nominated three individuals from the frequent flier list (part of the analysis step) to become COT Force's inaugural clients. These three individuals had a combined total of 401 arrests (of the 1070) and 116 of those arrests occurred in the three years prior to the creation of COT Force (2006-2008). All three nominees agreed to become part of the COT Force program and signed ROIs.

Client 1 is a male who was in his mid-50s at the time he became a COT Force client. He had been arrested over 200 times in his lifetime, the majority for alcohol-related offenses. Arresting this individual had not changed his behavior, treated his mental illness, or assisted him with housing. As part of his COT Force plan, he entered treatment in the fall of 2009 and has maintained housing and recovery since then. Client 2 is also a male in his mid-50s. He has been

arrested over 120 times in his lifetime, with all but a handful for alcohol-related offenses as well. He was in and out of treatment for about one year and has maintained housing and recovery since the fall of 2010. And, Client 3, a male in his early 40s, has been arrested over 75 times, again the majority for alcohol-related offenses but also for a considerable number of trespass offenses⁷. Client 3 was in and out of treatment for a little over one year, maintained housing and recovery for three years and relapsed in early 2014. These are simplified descriptions of each client; detailed information on service engagement is missing given the amount of time that has passed and the fact that there is no central records management system for the COT Force (i.e., each agency has its own records management system).

Although there has been no formal process or outcome evaluation of COT Force to date, anecdotal evidence suggests that COT Force is meeting their goals of reducing criminal justice and public health system consumption by homeless, mentally ill ‘frequent fliers.’ One cannot deny that the first three clients created criminal justice system savings solely through reduced arrests. Since the original three clients, COT Force has served an estimated 92 clients. In addition to reduced arrests, clients are demonstrating increased engagement in mental health and/or substance abuse services, and spending more time in housing and less time on the streets.

The Importance of Partnerships in Problem-Solving

First, homelessness is everyone’s issue, not just the police department’s. Often unacknowledged by society, the police are frequently the first point of contact for many homeless individuals. But they should not be solely responsible for solutions; partnerships and collaboration are really the best way to address these criminal justice issues in the future (Council of State Governments 2002; Klofas et al. 2010; Lamb et al. 2002; Normore et al. 2015).

⁷ It is not uncommon for homeless individuals to incur a high number of trespassing arrests. These arrests are typically related to their use of private property (usually a business) for sleeping, panhandling, eating, etc.

IMPD had to find another way to approach homelessness in Indianapolis. What they had been doing was not working and had created legal action against the City. COT Force, it seems, was born out of necessity. Simply acknowledging that there is more than one way to work with the homeless and mentally ill was a huge step for all involved.

Second, the collective mission of serving the homeless individual with mental health issues must be the priority (Normore et al. 2015). Therefore, the focus on partnerships and trust is critical to both inter-agency collaboration between COT Force members and serving the clients. The process of recovery takes time and patience. Each member of COT Force and the HPU recognizes that a homeless individual has to be ready to take the steps necessary to address the cause of his or her homelessness; it is the role of the police force and social services to establish trust, make contact early and often through outreach to homeless individuals and camps, regularly, and involve partnering agencies in each stage. COT Force would not function without partnerships and trust as priorities to reach the common goal.

Third, partnerships allow for flexibility in responses. Individuals find themselves homeless for a wide range of reasons and conditions, therefore responses must be tailored to the individual by necessity. The context surrounding each homeless individual is unique and therefore there is no 'one size fits all' manner with which to get an individual into housing and/or treatment or even to agree to participate in COT Force. With no formal standard operating procedures or formal rules and regulations, all actions grow out of the ROI. This agreement allows the group to discuss clients and tailor a response that fits each client's needs. And, COT Force members from each participating agency are deeply ingrained in their agencies and know their agencies' resources and rules. This allows each member to get things done even if it sometimes requires flexing of the rules. It frequently takes considerable trial and error to find the

right formula for each person. Relationships are crucial and a lot of the hard work is relationship building- both at the individual level and the agency level.

This pilot case study is not without limitations and any claims regarding success and future studies of COT Force should be informed by these limitations. As noted earlier, this project, like many police problem solving efforts lacks the necessary components for a rigorous formal evaluation (see, Weisburd et al. 2010). Due to the nature of the partnerships and the multi-agency collaboration, detailed data on services (dates, types, etc.) obtained by in clients were unavailable. A formal outcome evaluation would quantitatively measure the efficacy of what is happening in Indianapolis and strengthen the anecdotal evidence that indicates some success. Every effort should be made to find a suitable control group. Future studies should seek to determine if COT force keeps homeless individuals out of the criminal justice system when not necessary; survival rates could be measured along a host of variables such as maintaining housing, maintaining sobriety or mental health stability, and especially life expectancy. At the same time, current resources do not allow COT Force to enlist every homeless individual. Perhaps there is a diffusion of benefits to others experiencing homeless but who are not COT Force clients.

Conclusion

Society has come to rely on the criminal justice system to solve people's problems (Johnson 2011) and too often crisis drives policy (see, for example, Slate et al. 2013). The deinstitutionalization movement reaffirmed this reliance by expanding the role of police officers as gatekeepers for the mentally ill to both the criminal justice and mental health systems (Lamb et al. 2002). The high incidence of mental illness in the homeless population only makes the issue more complex. CIT-like programs have changed the way trained police officers interact

with the mentally ill and their families at times of crises, for example, through active listening and de-escalation techniques. At the same time, not all police interactions with the mentally ill happen at times of trauma or emergency; multiagency response is necessary to respond to homelessness and make meaningful change (Slate et al. 2013).

In Indianapolis, the police department is leading the effort to bring together the necessary agencies to respond to the homeless population *before* a crisis occurs. Grounded in partnerships, the COT Force and the HPU are working to solve problems at the individual level, one at a time, making every effort to keep homeless individuals out of the criminal justice system if they do not need to be there, encourage homeless individuals into whatever treatment is appropriate, and work to end homelessness one person at a time through repetitive individual contact and supportive services. Police should consider similar multi-agency ‘upstream’ approaches (Wood et al. 2011; Wood and Beierschmitt 2014) to address homeless individuals suffering from mental illness as well as for other public safety issues where chronic consumption of police and public safety resources could be reduced. These partnerships allow for a problem-solving approach that reaches well beyond that solely of the police (Normore et al. 2015).

However, twenty five years after he first conceptualized POP, Herman Goldstein criticized the POP movement saying that many police agencies are only implementing POP projects superficially (Goldstein 2003). Indeed, effective implementation of multi-agency initiatives is difficult and often such efforts fail or have unintended results (McGarrell and Hipple 2014). Additionally, the lack of rigorous evaluation is one of the signals that agencies are not fully investing in POP (Goldstein 2003). As mentioned at the outset, this project is no exception to Goldstein’s criticism due to the lack of formal evaluation.

Barriers to full implementation are not new to criminal justice projects. COT Force and the HPU have suffered from the same implementation pains other criminal justice initiatives have faced: limited financial resources, changing personnel, and lack of understanding at the agency level. Wood and Bradley (2009) suggest three essential conditions for a partnership policing effort like COT Force to work: capability, culture and accountability. They suggest these conditions at an agency level; however this case study would suggest it is possible for the police to meet the conditions and have a positive effect at a smaller level (i.e. unit) given upper management support (Wood and Bradley 2009). The police-led model based on partnerships presented here, while still formally untested, shows promise for jurisdictions working homeless, mentally ill populations collaboratively at the front line (Carpenter et al. 2016) . Finally, including a researcher in the problem-solving process can serve to further promote collaborative solutions to cross-system issues (Johnson 2011) through research and evaluation (Knutsson 2009). More practical research on police collaboration is necessary to create a ‘best practice’ empirical foundation upon which other police agencies may draw (Carpenter et al. 2016; Goldstein 2003).

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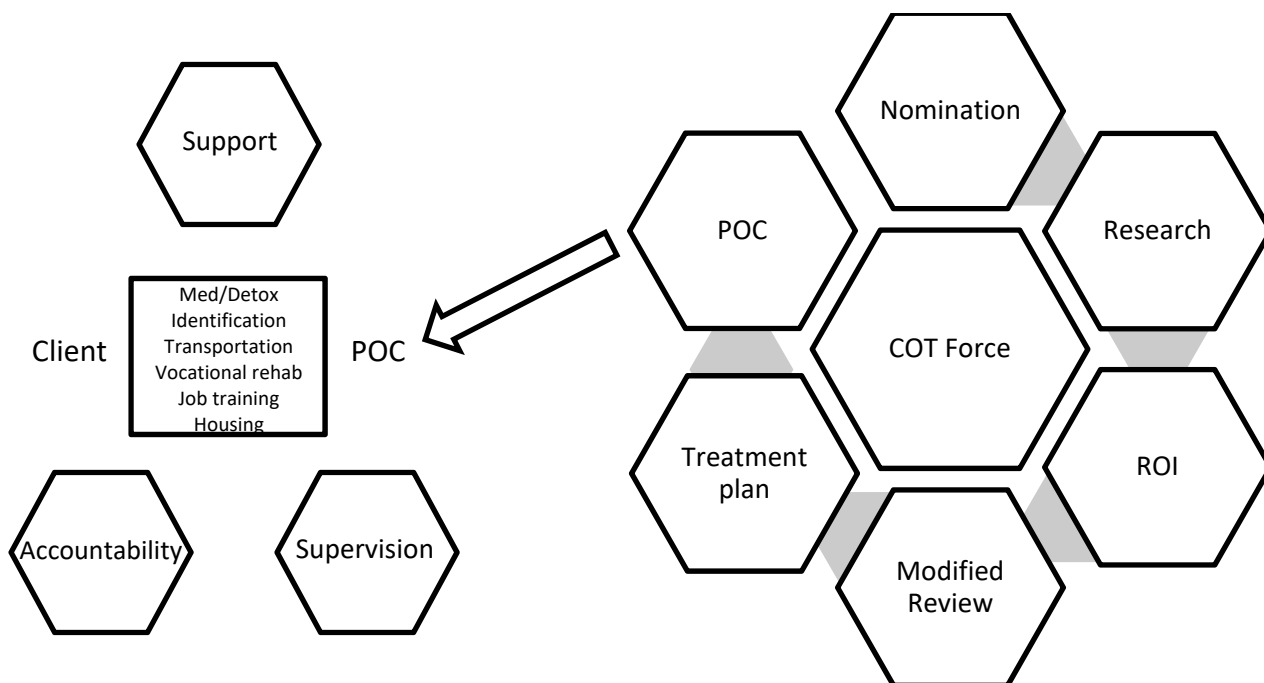
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Figure 1

The COT Force Process

Appendix A

Arrest Categories and Included Offenses for 'Top 20'

<u>Charge Category</u>	<u>Included Charges</u>	<u>Count</u>	<u>%</u>
Alcohol related	Operating a vehicle while intoxicated (all charges)	739	69.1
	Public intoxication		
Driving related	Driving never receiving a license	8	0.75
	Driving while license suspended		
	Obstruction of traffic		
Drug related	Dealing or possession of scheduled drug, controlled substance, cocaine, marijuana, paraphernalia	34	3.18
Fraud related	Forgery	1	0.10
Obstruction of justice	Bribery	36	3.36
	False reporting or informing		
	Resisting law enforcement		
Other		6	0.56
Personal related	Disorderly conduct	45	4.21
	Intimidation		
	Invasion of privacy		
	Panhandling		
Property crime related	Auto theft/Receiving stolen parts	131	12.24
	Burglary/Residential entry		
	Criminal conversion		
	Criminal mischief		
	Trespass		
	Theft/Receiving stolen property		
Sex crime related	Prostitution	17	1.59
	Public Indecency/Indecent exposure		
Violent crime related	Battery	52	4.86
	Criminal recklessness		
	Murder		
	Robbery		
	Strangulation		
Weapon related	Possession of a machine gun or loaded bomb	1	.10
Total		1070	100.0